SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Filing at a Glance

Company: Shelter Life Insurance Company

Product Name: Secure Whole Life	SERFF Tr Num: SHLI-126085021	State: Arkansas
TOI: L07I Individual Life - Whole	SERFF Status: Closed-Approved-Closed	State Tr Num: 41886
Sub-TOI: L07I.101 Fixed/Indeterminate Premium - Single Life	Co Tr Num: 03L10209	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Linda Bird
	Authors: Dina Krofta, Berdetta Moore	Disposition Date: 04/03/2009
	Date Submitted: 03/23/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Sec WL	Status of Filing in Domicile: Pending
Project Number: 10209	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 04/03/2009	Explanation for Other Group Market Type:
	State Status Changed: 04/03/2009
Deemer Date:	Created By: Berdetta Moore
Submitted By: Berdetta Moore	Corresponding Filing Tracking Number: 03L10209

Filing Description:

Form L-946 is a non-participating whole life insurance policy with maturity at age 120. The underwriting classes are male and female, standard and preferred (non-smoker). The issue age range is 15-80 for standard classes and 0-80 for preferred classes. It will be used with previously approved forms L-634 (Waiver of Premium), L-640 (Accidental Death Benefit) and L-639 (Guaranteed Insurance Rider).

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Form L-309.30 is an application for life insurance. It will also be used with previously approved form numbers L-001.12, L-001.17, L-631.2, L-883.2 , and L-705.15.

This policy contains only guaranteed elements and will not be illustration certified.

Shelter Life Insurance Company
1817 W. Broadway, Columbia, MO 65203
Group Number 123
NAIC Number 65757
Filing Number 03L10209

Contact Person: Berdetta Moore
Toll Free Number 800-shelter

Company and Contact

Filing Contact Information

Berdetta Moore, Actuarial Administrative Assistant	blmoore@shelterinsurance.com
1817 W. Broadway	573-214-4832 [Phone]
Columbia, MO 65203	573-214-6942 [FAX]

Filing Company Information

Shelter Life Insurance Company	CoCode: 65757	State of Domicile: Missouri
1817 W. Broadway Street	Group Code: 123	Company Type: Life and Health
Columbia, MO 65203	Group Name:	State ID Number:
(800) 743-5837 ext. [Phone]	FEIN Number: 43-0740882	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Shelter Life Insurance Company	$0.00	03/23/2009	

CHECK NUMBER	CHECK AMOUNT	CHECK DATE
1565247	$50.00	03/12/2009

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	04/03/2009	04/03/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Application	Note To Reviewer	Berdetta Moore	03/25/2009	03/25/2009

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Disposition

Disposition Date: 04/03/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Life & Annuity - Acturial Memo		No
Supporting Document	Statement of Variability		Yes
Form	Whole Life Insurance Policy		Yes
Form	Application for Life Insurance		Yes

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
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TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Note To Reviewer

Created By:

Berdetta Moore on 03/25/2009 07:28 AM

Last Edited By:

Linda Bird

Submitted On:

04/03/2009 09:37 AM

Subject:

Application

Comments:

The L946 may also be used with the previously approved application L-309.17.

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Form Schedule

Lead Form Number: L-946

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	L-946	Policy/Contract/Fraternal Certificate	Whole Life Insurance Policy	Initial		51.900	L-946.pdf
	L-309.30	Application/Enrollment Form	Application for Life Insurance	Initial		51.800	L-309.30.pdf

SHELTER LIFE INSURANCE COMPANY
A STOCK COMPANY

1817 WEST BROADWAY COLUMBIA, MO 65218-0001

SHELTER LIFE INSURANCE COMPANY WILL PAY the Death Benefit to the **Beneficiary** upon receipt of due proof that the **Insured's** death occurred during any **Policy Year**. Payment will be made only if this policy is in force on the date of the **Insured's** death.

This policy terminates at the **Maturity Date**.

20 Day Free Examination Period. Please examine Your policy. Within 20 days after delivery, You can return it to Us, or any Agent of The Company with a written request to cancel and You will receive a full refund of premiums. If We do not refund Your premium within 30 days from the date of cancellation, We will pay interest from the date of cancellation to the date of payment at the rate of interest specified in the insurance laws of Your state.

This policy is signed at **Our Home Office** in Columbia, Missouri.

Randa Fawlins
Secretary

J. David Moore
President and CEO

WHOLE LIFE INSURANCE
PREMIUMS PAYABLE FOR LIFE
NON-PARTICIPATING

READ THIS POLICY CAREFULLY.
This Policy is a legal contract between the Owner and Shelter Life Insurance Company.

INDEX

SHELTER LIFE INSURANCE COMPANY
1817 West Broadway
Columbia, MO 65218-0001
1-800-743-5837

Policy Schedule

INSURED: [JOHN DOE]

AGE: [30] [MALE]

POLICY NUMBER: [L000123456]

POLICY DATE: [FEBRUARY 1, 2009]

FACE AMOUNT: [125,000.00]

MATURITY DATE: [FEBRUARY 1, 2098]

PREMIUM CLASS: [STANDARD]

RISK CLASS: [STANDARD]

POLICY RIDERS: [WAIVER OF PREMIUM]
[ACCIDENTAL DEATH RIDER]
[GUARANTEED INSURABILITY RIDER]
[WAIVER OF PREMIUM RIDER FOR DEATH OR DISABILITY OF PAYOR]

CURRENT PREMIUM BY MODE OF PAYMENT

ANNUAL	SEMI-ANNUAL	QUARTERLY	SPECIAL MONTHLY
[$702.50]	[$361.79]	[$184.40]	[$59.71]

(INCLUDING PREMIUM FOR RIDERS AND ANNUAL POLICY FEE OF $36.00)

BENEFIT DESCRIPTION	AMOUNT OF INSURANCE	ANNUAL PREMIUM	PAYABLE FOR
SECURE WHOLE LIFE	[$50,000.00]	[$400.00]	LIFE
[WAIVER OF PREMIUM]		[$]	TO AGE 65
[ACCIDENTAL DEATH RIDER]	[$]	[$]	TO AGE 70
[GUARANTEED INSURABILITY RIDER]	[$]	[$]	TO AGE 40
[WAIVER OF PREMIUM RIDER FOR DEATH OR DISABILITY OF PAYOR]		[$]	TO THE EARLIER OF PAYOR AGE 60 OR INSURED AGE 25

TABLE OF GUARANTEED POLICY VALUES

INSURED: [JOHN DOE]

END OF POLICY YEAR	ATTAINED AGE OF INSURED	CASH VALUE	REDUCED PAID-UP INSURANCE	EXTENDED TERM INSURANCE YEARS	EXTENDED TERM INSURANCE DAYS	LOAN VALUE
1	[31]	[$ 0]	[0]			[0]
2	[32]	[$ 0]	[0]			[0]
3	[33]	[$ 0]	[0]			[0]
4	[34]	[$ 125]	[1,250]		[147]	[$125]
5	[35]	[$ 750]	[7,000]	[2]	[214]	[$750]
6	[36]	[$1,250]	[11,250]	[4]	[199]	[$1,250]
7	[37]	[$1,875]	[16,250]	[7]	[22]	[$1,875]
8	[38]	[$2,500]	[20,750]	[9]	[161]	[$2,500]
9	[39]	[$3,250]	[26,000]	[11]	[316]	[$3,250]
10	[40]	[$3,875]	[29,750]	[13]	[123]	[$3,875]
11	[41]	[$4,625]	[34,125]	[14]	[294]	[$4,625]
12	[42]	[$5,500]	[39,000]	[16]	[90]	[$5,500]
13	[43]	[$6,250]	[42,625]	[17]	[32]	[$6,250]
14	[44]	[$7,125]	[46,625]	[17]	[350]	[$7,125]
15	[45]	[$8,000]	[50,250]	[18]	[211]	[$8,000]
16	[46]	[$8,875]	[53,625]	[18]	[464]	[$8,875]
17	[47]	[$9,750]	[56,625]	[19]	[89]	[$9,750]
18	[48]	[$10,750]	[60,000]	[19]	[195]	[$10,750]
19	[49]	[$11,750]	[63,000]	[19]	[255]	[$11,750]
20	[50]	[$12,750]	[65,750]	[19]	[276]	[$12,750]
[30]	AGE 60	[$41,250]	[103,500]	[14]	[240]	[$41,250]
[35]	AGE 65	[$51,375]	[108,875]	[12]	[287]	[$51,375]

THESE VALUES ARE FOR THE FACE AMOUNT OF INSURANCE. THESE VALUES ASSUME THAT ALL PREMIUMS HAVE BEEN PAID TO THE END OF THE YEAR SHOW. VALUES BETWEEN POLICY ANNIVERSARIES WILL BE ADJUSTED FOR ANY PREMIUM PAID AND TIME ELAPSED DURING THE YEAR. ANY AMOUNTS BORROWED WILL DECREASE THESE VALUES. VALUES FOR YEARS NOT SHOWN WILL BE FURNISHED ON REQUEST.

BASIS OF COMPUTATION: CASH VALUES ARE BASED ON THE 2001 COMMISSIONERS STANDARD ORDINARY MORTALITY TABLE, MALE/FEMALE, SMOKER/NON-SMOKER, [4.25%] INTEREST, SEMICONTINUOUS FUNCTIONS, ON AGE LAST BIRTHDAY BASIS.

NONFORFEITURE INTEREST RATE: [4.25%] PER YEAR

POLICY RIDERS

The policy riders, if any, listed on the Policy Schedule are described in the rider agreements that follow page 11.

DEFINITIONS

The terms below will have the following definitions when bold and capitalized.

Beneficiary(ies): The person(s) who is (are) named in the application or by later designation to receive the Death Benefit of this policy.

Evidence of Insurability: Information about an **Insured** which is used to approve or reinstate this policy or any rider(s).

Home Office: 1817 West Broadway, Columbia, Missouri 65218-0001.

Insured: The person whose life is insured under this policy as shown on the Policy Schedule.

Loan: Any outstanding amount borrowed from in this policy.

Maturity Date: The **Policy Anniversary** following the Insured's 120th birthday. The policy terminates on the **Maturity Date**.

Monthly Date: The same day in each month as the Policy Date.

Policy Anniversary: The same month and day as the Policy Date for each succeeding year this policy remains in force.

Policy Year: A one year period of time starting on successive policy anniversaries, with the first **Policy Year** starting on the policy date.

Rate Class: The mortality or morbidity classifications assigned to the **Insured** under this Policy as specified by the Premium Class and the Risk Class.

We, Our, Us, The Company: Shelter Life Insurance Company.

You, Your: The Owner of this policy.

OWNERSHIP; ASSIGNMENT

Owner - The **Insured** will be the Owner unless otherwise stated. **You** may exercise all policy rights, except for proceeds which are to be paid to the **Beneficiary**. **Your** rights will be subject to the rights of an assignee or irrevocable **Beneficiary**. If **You** die before the **Insured**, **Your** estate will become the Owner unless otherwise provided. If the Owner is a partnership, the rights belong to the partnership as it exists when a right is exercised.

Successor Owner - **You** may designate a Successor Owner. This must be made by written notice to **Us**. When **You** die, the Successor Owner becomes the new Owner. If no Successor Owner survives, **Your** estate becomes the new Owner.

Change of Ownership - The ownership change must be made while the **Insured** is living by filing at **Our Home Office** written notice satisfactory to **Us**. The change will take effect on the date the requested change is approved and recorded by **Us**. **We** will not be liable for payment made or action taken prior to approval and recording of the requested change.

Assignment - Assignment of this policy will be binding on **Us** only after a copy of the assignment is received at the **Home Office**. **We** are not responsible for the validity of any assignment. If the assignment is absolute, all rights of the Owner and any revocable **Beneficiary** are transferred to the assignee. If the assignment is collateral, such rights are transferred only to the extent of the assignee's interest.

DEATH BENEFIT

Death Benefit - The amount payable at the death of the **Insured** will be the sum of:

1) the Face Amount in force at death;
2) any insurance provided by attached riders
3) any premium refund due: and

Less:

1) any **Loan** and Loan Interest as of the date of death; and
2) any premium due and unpaid for the period to the end of the policy month of death.

Proceeds payable will include interest if required by state law.

PAYMENTS OF BENEFITS

Succession in Interest of Beneficiaries - Unless otherwise stated in this policy, including any settlement agreement or in a **Beneficiary** designation in effect under this policy, the following provisions apply:

1. A **Beneficiary** is either a primary **Beneficiary** or a contingent **Beneficiary**. If no primary **Beneficiary** survives the **Insured**, then any proceeds are payable to the contingent **Beneficiary**.
2. The interest of any surviving primary **Beneficiary** in any proceeds payable is paramount to and exclusive of the interest of any contingent **Beneficiary**.
3. All **Beneficiaries** in the same class will share equally.
4. Proceeds will be paid to the **Beneficiaries** living at the time of the **Insured's** death.
5. Any proceeds payable after the death of all designated **Beneficiaries** will be paid to: (a) the Owner; or (b) the successors, transferees or estate of the Owner. However, the withdrawal value of any remaining guaranteed payments due or to become due will be paid in one sum to the estate of the person or persons then receiving such payments.

We may rely on the affidavit of the **Insured's** executor or estate administrator to determine the identity or nonexistence of **Beneficiaries** identified by class and not by name.

Claims Against Beneficiaries - To the extent allowed by law, no payment of proceeds or interest will be subject to: (a) claims of a **Beneficiary's** creditors; or (b) legal process against a **Beneficiary**.

Change of Beneficiary - **You** may change the **Beneficiary** by submitting a written request with **Us**. The change of **Beneficiary** request will not be effective until approved and recorded by **Us** at **Our Home Office**. Once approved and recorded, the change will be effective as of the date **You** signed the request, whether or not **You** or the **Insured** is alive when **We** record the change. However, the change will be subject to any payments made or other actions taken by **Us** before **Your** request was approved and recorded at **Our Home Office**.

THE CONTRACT

Consideration; Entire Contract - This policy is issued in consideration of: (a) the attached application; and (b) the payment of premiums. This policy and the application are the entire contract between the Owner and **Us**. Statements made in the application are considered representations and not warranties, except in the case of fraud. No statement will void this policy or be used as a defense to claim unless made in the application.

Modification of Policy - No agent has authority to change this policy or waive any of its provisions. Only an officer of **The Company** may make or modify this policy.

Policy Date - Policy months, years and anniversaries are measured from the policy date, as shown on the Policy Schedule.

Effective Date - This policy will be effective as soon as it has been accepted by the Owner and the first premium has been paid during the lifetime and continued insurability of the proposed **Insured**. If the first premium is paid in exchange for a conditional coverage receipt on the date of the application, then this policy will be effective as stated on the receipt.

Payments by Us - Any amount payable by **Us** will be made at **Our Home Office** in Columbia, Missouri. **We** may require surrender of the policy.

Incontestability - This policy will not be contestable after it has been in force during the **Insured's** lifetime for two years from the policy date, except for non-payment of premium.

Suicide - If the **Insured** commits suicide, while sane or insane, within two years (one year in Colorado and Missouri) from the Policy date, the amount payable by **Us** will be limited to the premium paid.

Modified Endowment Contract – Certain policies may be or become Modified Endowment Contracts (MECs) under Section 7702A of the Internal Revenue Code of 1986. We will notify **You** if **Your** policy becomes a MEC. If **Your** policy is or becomes a MEC and is later exchanged into another policy, **You** may have adverse income tax consequences. Shelter Life Insurance Company and its representatives do not provide tax advice. Please consult **Your** tax advisor to determine any tax implications.

Age; Sex - The age of the **Insured** is the age last birthday on the policy date or on a **Policy Anniversary**, determined from the birth date shown in the application. If the age or sex shown on the Policy Schedule is not correct, any amount payable will be the amount the premium would have purchased at the true age and sex on the basis of published rates used by **Us** on the Policy Date.

Reduction in Rate Class - **You** may request that **We** reduce the **Rate Class** assigned to the **Insured**. **We** will allow a reduction in **Rate Class** if **We** receive satisfactory evidence that the **Insured** qualifies. Any evidence **We** may require must be provided by a medical examiner approved by **Us**. A new policy will not be issued; however, a new Policy Schedule will be provided to **You**.

PREMIUMS

Payment - The first premium is due on the Policy Date. Due dates of later premiums are measured from that date. All premiums after the first are payable in advance: (a) at **Our Home Office**; or (b) to one of **Our** agents. Upon request, **We** will give **You** a receipt signed by **Our** Secretary. Premiums may be paid annually, semi-annually, quarterly or monthly at the published rates used by **Us** on the Policy Date. Payment of premiums is subject to **Our** current minimum premium requirements and permitted methods of payment.

This policy terminates on the due date of any premium not paid on or before that date, subject to the Grace Period provision.

Grace Period - A Grace Period of 31 days will be allowed for payment of any premium after the first. This policy will remain in force during the Grace Period. At least 30 days prior to termination of coverage, **We** will send a notice of such termination to **You** and any assignee of record.

Reinstatement –This policy may be reinstated to restore coverage within five years of lapse of policy provided the **Insured** is living. **Your** policy may not be reinstated after it has been surrendered. Reinstatement is subject to:

(1) **Evidence of Insurability** satisfactory to **Us**; and
(2) Payment of all overdue premiums with compound interest of 6% per year.

If this Policy is reinstated, the time period for the Incontestability provision will begin again at the time of reinstatement. **Our** only basis for contesting a reinstated policy beyond the policy's original contestable period is for material misstatements made in the reinstatement application.

Premium Adjustment At Death - Any part of a premium which pays beyond the next **Monthly Date** following the date of death will be returned. If death occurs during a grace period, any part of any unpaid premium to the next **Monthly Date** following the date of death will be deducted from the benefits paid.

Refund of Unearned Premiums - If this policy is terminated at **Your** request, **We** will refund any unearned premiums for the remainder of the period beyond the next **Monthly Date** following termination for which premiums were paid.

GUARANTEED VALUES

Computation of Reserves - The Commissioners 2001 Standard Ordinary Smoker or Non-Smoker Mortality Table is used to establish reserves.

A detailed statement of the methods of calculations has been filed with the insurance supervisory official of the jurisdiction in which this policy was delivered.

CASH VALUE

CASH VALUE - The Table of Policy Values shows the Cash Value at the end of certain **Policy Years**. These values assume premiums have been paid to the end of the year shown. Upon request, **We** will furnish values for any date not shown.

CASH SURRENDER - **You** may surrender **Your** Policy for its Cash Surrender Value at any time during the **Insured's** life. **You** may also choose to use the Cash Surrender Value to provide lapse benefits as discussed in the Lapse Benefit provision. A request for surrender must be in writing. **We** may require return of **Your** Policy.

You may choose to receive the Cash Surrender Value in one sum or apply it under a payment option.

CASH SURRENDER VALUE - The amount payable upon surrender of **Your** Policy will be **Your** Policy's Cash Value less any **Loan** and Loan Interest as of date of surrender.

We may delay paying the Cash Surrender Value for up to six months from the request. If delayed more than 30 days, interest will be paid on the Cash Surrender Value at an annual rate of at least 2.5%.

LOAN

LOAN VALUE - The Loan Value is **Your** Policy's Cash Value at the end of the current **Policy Year**.

NET LOAN VALUE - The Net Loan Value on date of **Loan** will be the Loan Value less:

1. any unpaid balance of the premium to the current **Policy Year**;
2. any existing **Loan** and Loan Interest; and
3. any Loan Interest from the date of the **Loan** to the end of the current **Policy Year**.

BORROWING ON THE POLICY - **You** may borrow all or part of the Net Loan Value at any time **Your** Policy has such value. **Your** Policy will be assigned to **Us** as sole security for the **Loan**. **We** may defer making a **Loan** for up to 6 months, except to pay a premium due. No **Loan** will be granted if **Your** Policy is in force as Extended Term Insurance. **You** may be asked to sign a **Loan** agreement.

LOAN INTEREST - The maximum annual interest rate will be 8%. **We** may set a lower rate. This rate will not be increased more than once a year. No increase will be more than 1%. If **You** have an existing **Loan**, **We** will give notice of an increase in interest rate at least 30 days before the increase goes into effect.

Interest accrues daily from the date of **Loan**. Interest is due on each **Policy Anniversary** and on the date the **Loan** is repaid. Interest not paid when due will be added to the **Loan**.

LOAN REPAYMENT - A **Loan** may be repaid in full or in part at any time before the **Insured's** death or surrender of **Your** Policy. If at any time the unpaid **Loan**, including any accrued interest, exceeds the Loan Value, **Your** Policy will terminate 31 days after **We** mail a notice of termination to **Your** last known address and to any assignee of record.

AUTOMATIC PREMIUM LOAN (APL) - APL may be selected in the application or by **Your** written request to **Us** while no premium is in default.

If APL has been selected, any premium not paid before the end of the Grace Period will be paid by charging the premium as a **Loan** against **Your** Policy, provided that the resulting **Loan** and Loan Interest to the end of the current **Policy Year** do not exceed the Loan Value. If the premiums cannot be paid by APL, the Lapse Benefits provision will apply.

You may revoke the APL at any time by written request to **Us**.

LAPSE BENEFITS

POLICY LAPSE - If a premium is not paid by the end of the Grace Period, **Your** Policy will lapse as of the premium due date. If **Your** Policy has no Cash Value, all insurance will terminate at the time of lapse. **You** may withdraw any Cash Surrender Value of **Your** Policy as of the lapse date. If the Cash Surrender Value is not withdrawn, it will be used to continue **Your** Policy in force as Extended Term Insurance or Paid-Up Insurance and all riders will be terminated.

EXTENDED TERM INSURANCE - This is non-participating paid-up term insurance on the **Insured's** life for a limited period of time. The amount of Extended Term Insurance will be determined as of the lapse date and will be the Face Amount of **Your** Policy less any **Loan** and Loan Interest.

The Cash Surrender Value of **Your** Policy on the lapse date will be used as a net single premium at the attained age of the **Insured** to determine the period of time that Extended Term Insurance will continue.

PAID-UP INSURANCE - This is paid–up insurance for the **Insured's** life. The Cash Surrender Value of **Your** Policy on the lapse date will be used as a net single premium at the attained age of the **Insured** to determine the amount of paid-up insurance to be provided.

CASH SURRENDER VALUE AFTER LAPSE - If **Your** Policy is in force as Extended Term Insurance or Paid-Up Insurance after lapse, **You** may surrender it for the then current Cash Surrender Value. A request for surrender must be in writing. If the request is made within 31 days after a **Policy Anniversary**, the Cash Surrender Value will not be less than it was on that **Policy Anniversary**.

SELECTION OF LAPSE BENEFIT - If no lapse benefit has been selected within thirty-one days of the lapse date and if APL is not in effect, **Your** Policy will be continued as Extended Term Insurance. However, **Your** Policy will be continued as Paid-Up Insurance if it is in a special premium classification or if an equal or greater amount of insurance will be provided under Paid-Up Insurance. **You** have the right to select any other available Lapse Benefit within 60 days after the lapse date.

OPTIONAL INCOME PAYMENT OF PROCEEDS

Election of Payment Option - **You** may elect any of the following options while the **Insured** is alive. If the proceeds are payable in one sum when the **Insured** dies, the **Beneficiary** may elect an option. Any option election must be in writing. It must be received by **Us**.

Payment options are available only to natural persons. Options 1, 2 and 3 may not exceed 30 years.

PAYMENT OPTIONS

Option 1. Held at Interest - **We** will hold the amount applied under this option. Interest will be paid at the rate of at least 2.5% per year. Interest payment intervals of 12, 6, 3 or 1 month may be selected.

Option 2. Payments of a Selected Amount - Each payment will be for the amount selected. The amount may not be less than $20. Payment intervals of 12, 6, 3 or 1 month may be selected. Payments will be made until the amount applied plus interest of at least 2.5% per year is exhausted. The last payment will be for the balance only.

Option 3. Selected Number of Payments - Equal payments will be made for the number of payments selected. The amount of each payment depends on: the total amount applied; the number of payments selected; and the interval of payment. Payment intervals of 12, 6, 3 or 1 month may be selected. The following table shows the amount of payment for each $1,000 applied.

Amount of Installments

Years Payable	Annual	Semi-Annual	Quarterly	Monthly
1	$1,000.00	$503.09	$252.32	$84.28
2	506.17	254.65	127.72	42.66
3	341.60	171.85	86.19	28.79
4	259.33	130.47	65.44	21.86
5	210.00	105.65	52.99	17.70
6	177.12	89.11	44.69	14.93
7	153.65	77.30	38.77	12.95
8	136.07	68.45	34.33	11.47
9	122.40	61.58	30.88	10.32
10	111.47	56.08	28.13	9.39
11	102.54	51.59	25.87	8.64
12	95.11	47.85	24.00	8.02
13	88.83	44.69	22.41	7.49
14	83.45	41.98	21.06	7.03
15	78.80	39.64	19.88	6.64
16	74.73	37.60	18.86	6.30
17	71.15	35.79	17.95	6.00
18	67.97	34.20	17.15	5.73
19	65.13	32.77	16.43	5.49
20	62.58	31.48	15.79	5.27
21	60.28	30.33	15.21	5.08
22	58.19	29.28	14.68	4.90
23	56.29	28.32	14.20	4.74
24	54.55	27.44	13.76	4.60
25	52.95	26.64	13.36	4.46
26	51.48	25.90	12.99	4.34
27	50.12	25.22	12.65	4.22
28	48.87	24.58	12.33	4.12
29	47.70	24.00	12.04	4.02
30	46.61	23.45	11.76	3.93

Option 4. Life Income - Payments will be made for a selected guaranteed period of 10, 15 or 20 years. Payments will stop at the end of the selected period or when the payee dies, whichever is later. The amount of each monthly payment depends on: the total amount applied; and the sex and age of the payee when payments begin. The age of the payee is figured on age last birthday. **We** may require proof of age and sex of the payee before payments begin. **We** may also require proof that the payee is living at the time any payment is made. The following table shows the amount of monthly payment for each $1,000 applied.

MONTHLY INSTALLMENTS

	Age	Guaranteed Period		
		10 Years	15 Years	20 Years
MALE				
	5	$2.46	$2.45	$2.45
	15	2.59	2.58	2.58
	25	2.77	2.77	2.76
	35	3.05	3.04	3.03
	45	3.47	3.45	3.42
	55	4.13	4.07	3.97
	65	5.21	4.96	4.63
	75	6.82	5.96	5.12
	85	8.46	6.52	5.26
FEMALE				
	5	$2.40	$2.40	$2.40
	15	2.52	2.52	2.52
	25	2.68	2.68	2.68
	35	2.92	2.91	2.91
	45	3.28	3.27	3.25
	55	3.85	3.81	3.76
	65	4.80	4.67	4.45
	75	6.41	5.78	5.07
	85	8.32	6.49	5.26

Monthly payments for ages not shown will be furnished on request.

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WHOLE LIFE POLICY
PREMIUMS PAYABLE FOR LIFE
NON-PARTICIPATING

SHELTER LIFE INSURANCE COMPANY
1817 WEST BROADWAY
COLUMBIA, MO 65218-0001

CONTRACT

Agent Name_____

Agent # _____

Agent Telephone #_____

Applicant's Family #_____

SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

LIFE INSURANCE APPLICATION

PROPOSED INSURED

1. Name (Last) (First) (MI) (Suffix) | Soc. Sec. No. | ☐ Male ☐ Female
2. Marital Status | Hgt. ' " | Wgt. lbs. | Birth Date | Age | State of Birth
3. Address (Street) (City) (County) (State) (Zip)
4. Home Phone | Cell Phone | Best Time to Contact
5. Driver's License No. State
6. Country of Citizenship: ☐ US ☐ Other
   If Other, provide the following: Country of Citizenship _____ Length of Residency in US _____
   Visa Type: ☐ Permanent ☐ Temporary If Temporary, Category Expiration Date
7. Occupation | Name of Employer | Date Employed

Annual Earned Income $ | Income All Sources $

BENEFICIARY

8. Primary (List name, address, age, relationship, Payment Option) (If a trust, list name of Trustee, name & date of Trust)

Contingent

TERM / TRADITIONAL

9. ☐ 10 Yr. Level Term ☐ Whole Life ☐ YRT to 85
   ☐ 20 Yr. Level Term ☐ 20 Pay Whole Life ☐
   ☐ 30 Yr. Level Term ☐ Secure Whole Life ☐
   Face Amount $ | Mode Premium $
10. Rate Class: (Level Term & YRT) ☐ STD ☐ STD/NT ☐ PRF/NT (All other policies) ☐ STD ☐ NT
11. WP ☐ Yes ☐ No | AD ☐ Yes Amount $_____ ☐ No | Auto Prem Loan ☐ Yes ☐ No (Not available on term insurance)
12. Dividend Options: (WL & WL 20 Pay Only) ☐ Pd. Up. Adds ☐ Accum. at Interest ☐ Cash ☐ Reduce Premium (N/A on Special Monthly)

UNIVERSAL

13. ☐ Specified Amount - New Policy $ | Target Prem $ | Planned Prem (If more than Target) $
14. ☐ Specified Amount - Increase $ to UL Policy # | Planned Prem after Increase $
15. Rate Class: ☐ STD ☐ NT | ☐ Option A (Level) ☐ Option B (Increasing) | WMD ☐ Yes ☐ No | AD ☐ Yes ☐ No

RIDERS

16. ☐ Paid Up Additional Insurance Rider Premium Amount (WL and 20 Pay WL) $_____ 1035 Exchange ☐ Yes ☐ No
17. ☐ Guaranteed Insurability Rider - Amount $ | 18. ☐ Payor Death and Disability Benefit (WL and 20 Pay WL)
19. Payor To Be Insured | Relationship | Sex | Hgt | Wgt | Birth Date | Age | US Cit? | Birth St. | SS No.

Payor's Occupation | Payor's Address

PREMIUM

20. ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Payroll Deduction
    ☐ PAC - Withdrawal Day of Month _____ Send Form & Void Check ☐ Government Allotment (Except YRT)
    ☐ Special Billing - Name & Address of Company _____
    Remarks _____
    ☐ Prem included with application $ ☐ COD | ☐ Paid Up Additional Insurance Rider Prem Collected $
21. Name and address of person paying premium **only if** other than proposed insured or owner

IN FORCE

22. a. Total individual life insurance and accidental death coverage in force or pending (excluding this application) in all companies including Shelter Life:	(Life) $	(Accidental Death) $	
b. If Proposed Insured is under 16, show amount of life insurance on:	(Father) $	(Mother) $	(Sibling[s]) $

REPLACEMENT

23. Will this insurance replace or change any existing life insurance policy or annuity contract with any company including Shelter Life?
☐ Yes ☐ No If Yes, list name of company, policy number, face amount and send replacement form(s) with application.

QUESTIONS 24 THROUGH 40 MUST BE ANSWERED FOR EACH PERSON TO BE INSURED INCLUDING APPLICANTS FOR SPOUSE'S TERM RIDER, CHILDREN'S TERM RIDER & PAYOR BENEFIT.

UNDERWRITING INFORMATION

24. List attending physician(s) for proposed insured(s) and provide name, address, phone number, date and reason for most recent consultation(s), treatment received and medications prescribed:

Physicians name, address and telephone number	Date/Reason/Diagnosis/Treatment/Medications Prescribed

	Yes	No
25. Do you have a parent, brother or sister who:		
a. has a history of diabetes, heart or kidney disease, or hypertension?	☐	☐
b. died before age 60? If yes, list relationship, age & cause of death in qt. 32	☐	☐
26. Have you engaged in or do you anticipate engaging in:		
a. Aviation activities, including ultralight flying, hang gliding or parachute jumping?	☐	☐
b. Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby?	☐	☐
27. In the past 5 years have you been charged with any Motor Vehicle violations or violations for driving while intoxicated from alcohol or drugs?	☐	☐
28. Are you planning travel, residence or employment outside the United States?	☐	☐
29. Do you now use or have you ever used any form of tobacco or nicotine substitutes? If yes, give date last used in qt. 32.	☐	☐
30. Are you in the National Guard or Reserves?	☐	☐
31. Have you been charged with any Misdemeanor or Felony? If yes, give details such as type of offense, date, and whether or not convicted in qt. 32.	☐	☐

32. FOR ALL YES ANSWERS TO QUESTIONS 25 THRU 31. GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Date	Details

QUESTIONS 33 THROUGH 40 MAY BE OMITTED IF A MEDICAL EXAM IS REQUIRED.

UNDERWRITING INFORMATION

	Yes	No
33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for:		
a. hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease of the heart or blood vessels?	☐	☐
b. cancer, tumor or other growth or malignancy of any kind?	☐	☐
c. bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system?	☐	☐
d. depression, anxiety or any other behavioral, mental or nervous disorder?	☐	☐
e. epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system?	☐	☐
f. diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands?	☐	☐
g. arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin?	☐	☐
h. any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system?	☐	☐
i. any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy?	☐	☐
j. Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder?	☐	☐
34. If female, are you now pregnant? If yes, give approximate delivery date in qt. 40.	☐	☐
35. Are you currently receiving treatment, taking medication, or scheduled to have surgery?	☐	☐
36. Weight loss of more than 10 lbs. in past year? If yes, list # of lbs. and reason in qt. 40.	☐	☐
37. Have you:		
a. used or do you now use cocaine, methamphetamines, marijuana or any other drugs? If Yes, list type, amount, frequency and date last used in qt. 40.	☐	☐
b. used or do you now use alcoholic beverages? If Yes, provide type, frequency and amount in qt. 40	☐	☐
c. sought or received treatment or counseling for alcohol or drug use?	☐	☐
38. Have you received or do you now receive disability benefits or do you currently have a disability of any kind?	☐	☐
39. In the past five years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above?	☐	☐

40. FOR ALL YES ANSWERS IN QUESTIONS 33 THRU 39 GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Describe Illness or Injury and Medical Attention	Date Mo Day Yr	Duration	Details Including Any Remaining Effects	Names, Addresses, and Phone Numbers of Physicians & Hospitals

41. List name, address, date of birth and relationship of OWNER if other than Proposed Insured.

42. List name, address and relationship of SUCCESSOR OWNER. (A successor owner is not required.)

43. Special Requests.

44. The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;

b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;

c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;

d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and

e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:

(1) a policy is delivered to the Owner during the lifetime of all persons proposed for insurance; and

(2) to the best of the Owner's and proposed insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

SIGNATURES/DECLARATION

45. THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER ..... ☐ Yes ☐ No

IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Dated this _____ day of _____, _____ at _____ ☐ A.M. ☐ P.M. in the city of_____ State of_____
Month Year Time

_____
Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

_____
Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

_____
Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

_____ _____ _____
Print Name of Writing Agent | Signature of Writing Agent | Agent's Number

AGENT'S STATEMENT

1. Does proposed insured have other life insurance in force with Shelter Life?
   ☐ Yes ☐ No If yes, give policy numbers

2. Has a Medical Examination and/or other testing been arranged? ☐ Yes ☐ No. SEE MANUAL FOR REQUIREMENTS.

3. If blood profile is required, have you attached the special blood test authorization form if one is required in your state? ☐ Yes ☐ No

4. Do you know or have any reason to believe that replacement of existing Life insurance is involved? ☐ Yes ☐ No
   If yes, give policy numbers, names and addresses of companies that issued such policies and expected date of lapse.

5. Does this application involve a 1035 exchange? ☐ Yes ☐ No (UL, PUA Only) If Yes, send appropriate form. ☐ External ☐ Internal

6. AS REQUIRED BY FEDERAL LAW, did you detach and give the NOTICE OF CONSUMER REPORT to the Proposed Insured (or Owner if the Proposed Insured is a juvenile)? ☐ YES.

7. Did you solicit this business? ☐ Yes ☐ No. If No, explain

8. Is any person applying for coverage related to you? ☐ Yes ☐ No. If Yes, give relationship

_____ _____
Signature of Writing Agent Agent's Number

MEDICAL TEST AUTHORIZATION

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, test for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

_____ _____
Date Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

_____ _____
Date Signature of Spouse, if applying

Authorization for Use or Disclosure
Of Protected Health Information

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

_____
Print Name and Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile Date

_____
Print Name and Date of Birth of Spouse, If Applying

_____ _____
Signature of Spouse, If Applying Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or owner **ONLY IF** premium is collected with application.

CONDITIONAL COVERAGE RECEIPT

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount $ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For_____ Face Amount $ _____

by _____ _____ _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive: (2) to your best knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be insured under the policy applied for prior to delivery will not exceed the lesser of: (a) $250,000, including accidental death benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.

SERFF Tracking Number:	*SHLI-126085021*	*State:*	*Arkansas*
Filing Company:	*Shelter Life Insurance Company*	*State Tracking Number:*	*41886*
Company Tracking Number:	*03L10209*		
TOI:	*L07I Individual Life - Whole*	*Sub-TOI:*	*L07I.101 Fixed/Indeterminate Premium - Single Life*
Product Name:	*Secure Whole Life*		
Project Name/Number:	*Sec WL/10209*		

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

CERTIFICATION-FLESCH-AR.pdf

Item Status: **Status Date:**

Satisfied - Item: Application

Comments:

This application is part of this filing submitted for approval.

Attachment:

L-309.30.pdf

Item Status: **Status Date:**

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability.pdf

SHELTER INSURANCE COMPANIES

SHELTER MUTUAL
SHELTER GENERAL
SHELTER LIFE

CERTIFICATION

This is to certify that the following forms have achieved the indicated Flesch Reading Ease Scores and comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form No.	Name	Score
L-946	Whole Life Policy	51.9
L-309.30	Application for Life Insurance	51.8

Signed Dina Krofta

Digitally signed by Dina Krofta
DN: cn=Dina Krofta, o, ou, email=dkrofta@shelterinsurance.com, c=US
Date: 2009.03.23 13:22:31 -05'00'

Dina Krofta, FSA, MAAA
Senior Life Actuary
Shelter Life Insurance Company

CONTRACT

Agent Name_____

Agent # _____

Agent Telephone #_____

Applicant's Family #_____

SHELTER LIFE INSURANCE COMPANY

1817 WEST BROADWAY, COLUMBIA, MISSOURI 65218-0001

LIFE INSURANCE APPLICATION

PROPOSED INSURED

1. Name (Last) (First) (MI) (Suffix) | Soc. Sec. No. | ☐ Male ☐ Female
2. Marital Status | Hgt. ' " | Wgt. lbs. | Birth Date | Age | State of Birth
3. Address (Street) (City) (County) (State) (Zip)
4. Home Phone | Cell Phone | Best Time to Contact
5. Driver's License No. State
6. Country of Citizenship: ☐ US ☐ Other
   If Other, provide the following: Country of Citizenship _____ Length of Residency in US _____
   Visa Type: ☐ Permanent ☐ Temporary If Temporary, Category Expiration Date
7. Occupation | Name of Employer | Date Employed

Annual Earned Income $ | Income All Sources $

BENEFICIARY

8. Primary (List name, address, age, relationship, Payment Option) (If a trust, list name of Trustee, name & date of Trust)

Contingent

TERM / TRADITIONAL

9. ☐ 10 Yr. Level Term ☐ Whole Life ☐ YRT to 85
   ☐ 20 Yr. Level Term ☐ 20 Pay Whole Life ☐
   ☐ 30 Yr. Level Term ☐ Secure Whole Life ☐
   Face Amount $ | Mode Premium $
10. Rate Class: (Level Term & YRT) ☐ STD ☐ STD/NT ☐ PRF/NT (All other policies) ☐ STD ☐ NT
11. WP ☐ Yes ☐ No | AD ☐ Yes Amount $_____ ☐ No | Auto Prem Loan ☐ Yes ☐ No (Not available on term insurance)
12. Dividend Options: (WL & WL 20 Pay Only) ☐ Pd. Up. Adds ☐ Accum. at Interest ☐ Cash ☐ Reduce Premium (N/A on Special Monthly)

UNIVERSAL

13. ☐ Specified Amount - New Policy $ | Target Prem $ | Planned Prem (If more than Target) $
14. ☐ Specified Amount - Increase $ to UL Policy # | Planned Prem after Increase $
15. Rate Class: ☐ STD ☐ NT | ☐ Option A (Level) ☐ Option B (Increasing) | WMD ☐ Yes ☐ No | AD ☐ Yes ☐ No

RIDERS

16. ☐ Paid Up Additional Insurance Rider Premium Amount (WL and 20 Pay WL) $_____ 1035 Exchange ☐ Yes ☐ No
17. ☐ Guaranteed Insurability Rider - Amount $ | 18. ☐ Payor Death and Disability Benefit (WL and 20 Pay WL)
19. Payor To Be Insured | Relationship | Sex | Hgt | Wgt | Birth Date | Age | US Cit? | Birth St. | SS No.

Payor's Occupation | Payor's Address

PREMIUM

20. ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Payroll Deduction
    ☐ PAC - Withdrawal Day of Month _____ Send Form & Void Check ☐ Government Allotment (Except YRT)
    ☐ Special Billing - Name & Address of Company _____
    Remarks _____
    ☐ Prem included with application $ ☐ COD | ☐ Paid Up Additional Insurance Rider Prem Collected $
21. Name and address of person paying premium **only if** other than proposed insured or owner

IN FORCE

22. a. Total individual life insurance and accidental death coverage in force or pending (excluding this application) in all companies including Shelter Life:	(Life) $	(Accidental Death) $	
b. If Proposed Insured is under 16, show amount of life insurance on:	(Father) $	(Mother) $	(Sibling[s]) $

REPLACEMENT

23. Will this insurance replace or change any existing life insurance policy or annuity contract with any company including Shelter Life?
☐ Yes ☐ No If Yes, list name of company, policy number, face amount and send replacement form(s) with application.

QUESTIONS 24 THROUGH 40 MUST BE ANSWERED FOR EACH PERSON TO BE INSURED INCLUDING APPLICANTS FOR SPOUSE'S TERM RIDER, CHILDREN'S TERM RIDER & PAYOR BENEFIT.

UNDERWRITING INFORMATION

24. List attending physician(s) for proposed insured(s) and provide name, address, phone number, date and reason for most recent consultation(s), treatment received and medications prescribed:

Physicians name, address and telephone number	Date/Reason/Diagnosis/Treatment/Medications Prescribed

	Yes	No
25. Do you have a parent, brother or sister who:		
a. has a history of diabetes, heart or kidney disease, or hypertension?	☐	☐
b. died before age 60? If yes, list relationship, age & cause of death in qt. 32	☐	☐
26. Have you engaged in or do you anticipate engaging in:		
a. Aviation activities, including ultralight flying, hang gliding or parachute jumping?	☐	☐
b. Rodeo riding, underwater diving, racing of any motor powered vehicle or any other hazardous sport or hobby?	☐	☐
27. In the past 5 years have you been charged with any Motor Vehicle violations or violations for driving while intoxicated from alcohol or drugs?	☐	☐
28. Are you planning travel, residence or employment outside the United States?	☐	☐
29. Do you now use or have you ever used any form of tobacco or nicotine substitutes? If yes, give date last used in qt. 32.	☐	☐
30. Are you in the National Guard or Reserves?	☐	☐
31. Have you been charged with any Misdemeanor or Felony? If yes, give details such as type of offense, date, and whether or not convicted in qt. 32.	☐	☐

32. FOR ALL YES ANSWERS TO QUESTIONS 25 THRU 31. GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Date	Details

QUESTIONS 33 THROUGH 40 MAY BE OMITTED IF A MEDICAL EXAM IS REQUIRED.

UNDERWRITING INFORMATION

	Yes	No
33. To the best of your knowledge and belief, have you ever been diagnosed or treated by a medical professional for:		
a. hypertension, coronary artery disease, stroke, heart attack, chest pain, irregular heartbeat, or any other disease of the heart or blood vessels?	☐	☐
b. cancer, tumor or other growth or malignancy of any kind?	☐	☐
c. bronchitis, emphysema, shortness of breath or any other disease or disorder of the lungs or respiratory system?	☐	☐
d. depression, anxiety or any other behavioral, mental or nervous disorder?	☐	☐
e. epilepsy, seizures, sleep apnea or any other disease or disorder of the brain or nervous system?	☐	☐
f. diabetes, hepatitis, anemia or any other disease or disorder of the blood or glands?	☐	☐
g. arthritis, gout, or any other disease or disorder of the bones, muscles, joints, eyes or skin?	☐	☐
h. any disease or disorder of the stomach, intestines, colon, rectum, liver, pancreas or digestive system?	☐	☐
i. any disease or disorder of the kidney, bladder, prostate, urinary system or genital organs including complication of pregnancy?	☐	☐
j. Acquired Immune Deficiency Syndrome (AIDS), positive HIV test, or other immunological disorder?	☐	☐
34. If female, are you now pregnant? If yes, give approximate delivery date in qt. 40.	☐	☐
35. Are you currently receiving treatment, taking medication, or scheduled to have surgery?	☐	☐
36. Weight loss of more than 10 lbs. in past year? If yes, list # of lbs. and reason in qt. 40.	☐	☐
37. Have you:		
a. used or do you now use cocaine, methamphetamines, marijuana or any other drugs? If Yes, list type, amount, frequency and date last used in qt. 40.	☐	☐
b. used or do you now use alcoholic beverages? If Yes, provide type, frequency and amount in qt. 40	☐	☐
c. sought or received treatment or counseling for alcohol or drug use?	☐	☐
38. Have you received or do you now receive disability benefits or do you currently have a disability of any kind?	☐	☐
39. In the past five years, have you consulted any physician or health care facility, been hospitalized, had any abnormal diagnostic tests or been advised to have treatment for any reason not explained above?	☐	☐

40. FOR ALL YES ANSWERS IN QUESTIONS 33 THRU 39 GIVE FULL DETAILS BELOW.

Question No.	Name of Person	Describe Illness or Injury and Medical Attention	Date Mo Day Yr	Duration	Details Including Any Remaining Effects	Names, Addresses, and Phone Numbers of Physicians & Hospitals

41. List name, address, date of birth and relationship of OWNER if other than Proposed Insured.

42. List name, address and relationship of SUCCESSOR OWNER. (A successor owner is not required.)

43. Special Requests.

44. The Owner and Proposed Insured, if other than the Owner, each declares that he or she has read the answers recorded in this application and that they are complete and true to the best of his or her knowledge and belief, and agrees that:

a. this application and any amendments to it and any statements made and recorded on the medical examination form shall become the basis for and be a part of any contract of insurance;

b. any policy or rider issued on the basis of this application will belong to and be solely under the control of the Owner;

c. only the Shelter Life Insurance Company, at its Home Office, may make or modify contracts or waive any of its rights or requirements, and then only in writing;

d. no Agent of Shelter Life Insurance Company and no Medical Examiner is authorized to accept or pass upon insurability; and

e. except as provided in the Conditional Coverage Receipt, if issued, insurance will not be effective unless:

(1) a policy is delivered to the Owner during the lifetime of all persons proposed for insurance; and

(2) to the best of the Owner's and proposed insured's knowledge there has been no material change in the answers herein since the date of this application or the completion of all medical examination requirements.

SIGNATURES/DECLARATION

45. THE OWNER DECLARES THAT THE CONDITIONAL COVERAGE RECEIPT HAS BEEN DETACHED FROM THIS APPLICATION AND GIVEN TO HIM OR HER ..... ☐ Yes ☐ No

IF "YES" THE OWNER FURTHER DECLARES THAT THE TERMS AND CONDITIONS OF THE CONDITIONAL COVERAGE RECEIPT HAVE BEEN BROUGHT SPECIFICALLY TO HIS OR HER ATTENTION AND THAT HE OR SHE UNDERSTANDS AND ACCEPTS THEM.

THE PROPOSED INSURED ACKNOWLEDGES RECEIPT OF THE NOTICE OF CONSUMER REPORT AND MIB PRE-NOTICE AS REQUIRED BY THE CONSUMER PROTECTION AGENCY.

THIS APPLICATION IS A LEGAL DOCUMENT. THE POLICY MAY BE ALTERED OR RESCINDED IF THE QUESTIONS ARE NOT ANSWERED CORRECTLY AND TRUTHFULLY.

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

Dated this _____ day of _____, _____ at _____ ☐ A.M. ☐ P.M. in the city of_____ State of_____
Month Year Time

_____
Signature of Proposed Insured or of Parent or Legal Guardian if Under Age 18

_____
Signature of Owner, if other than Proposed Insured, or of Parent or Grandparent Owner if Proposed Insured is Under Age 18

_____
Owner's Social Security Number

I HEREBY CERTIFY THAT I PERSONALLY ASKED EVERY QUESTION OF THE OWNER, AND PROPOSED INSURED IF OTHER THAN OWNER, AND ACCURATELY RECORDED THE ANSWERS GIVEN AND THAT I WITNESSED THE SIGNATURE(S) ABOVE.

_____ _____ _____
Print Name of Writing Agent | Signature of Writing Agent | Agent's Number

AGENT'S STATEMENT

1. Does proposed insured have other life insurance in force with Shelter Life?
   ☐ Yes ☐ No If yes, give policy numbers

2. Has a Medical Examination and/or other testing been arranged? ☐ Yes ☐ No. SEE MANUAL FOR REQUIREMENTS.

3. If blood profile is required, have you attached the special blood test authorization form if one is required in your state? ☐ Yes ☐ No

4. Do you know or have any reason to believe that replacement of existing Life insurance is involved? ☐ Yes ☐ No
   If yes, give policy numbers, names and addresses of companies that issued such policies and expected date of lapse.

5. Does this application involve a 1035 exchange? ☐ Yes ☐ No (UL, PUA Only) If Yes, send appropriate form. ☐ External ☐ Internal

6. AS REQUIRED BY FEDERAL LAW, did you detach and give the NOTICE OF CONSUMER REPORT to the Proposed Insured (or Owner if the Proposed Insured is a juvenile)? ☐ YES.

7. Did you solicit this business? ☐ Yes ☐ No. If No, explain

8. Is any person applying for coverage related to you? ☐ Yes ☐ No. If Yes, give relationship

_____ _____
Signature of Writing Agent Agent's Number

MEDICAL TEST AUTHORIZATION

I hereby authorize Shelter Life Insurance Company to obtain medical tests on blood, oral fluid or urine samples in connection with the underwriting of my application for insurance with Shelter Life Insurance Company.

I understand that such tests will be performed by laboratories selected by Shelter Life Insurance Company and may include, but are not limited to, test for cholesterol and related blood lipids, diabetes, hepatitis or other liver disorders, kidney disorders, infection by the Acquired Immune Deficiency Syndrome virus, immune disorders, or the presence of medications, drugs, nicotine, or their metabolites.

The results of these tests will be made known only to Shelter Insurance Companies and/or their reinsurers, and possibly the Medical Information Bureau as described in the Pre-Notice which was given to me as part of the application process. Positive HIV and hepatitis test results will be reported to your State Department of Health if we or the testing laboratory are required to do so by law. Test results will not be released to anyone else or any institution except as required by law, by court order or by written authorization from me to release it to a physician designated by me.

_____ _____
Date Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile

_____ _____
Date Signature of Spouse, if applying

Authorization for Use or Disclosure
Of Protected Health Information

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, MIB Group, Inc. or other organization, institution, or person, that has any records or knowledge of me or my health, to give to the Shelter Life Insurance Company, its Medical Director, its reinsurers, and Shelter Mutual Insurance Company, any and all such health information. I further authorize Shelter Life Insurance Company, and its reinsurers, to disclose such protected health information to MIB Group, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members.

2. I understand that this protected health information will be used to locate or underwrite insurance for me, or to determine whether a valid claim for benefits has been made. The information may also be disclosed by Shelter Life Insurance Company to MIB, who, upon request, may disclose such information about me in its file to another member company with whom I apply for life or health insurance or to whom a claim for benefits may be submitted.

3. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations.

4. I understand that the information in my health record may include information that may be considered a communicable or venereal disease that may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

5. This authorization is valid for 12 months from the date of signing. I understand that I may revoke this authorization at any time by sending written notification to Shelter Life Insurance Company, 1817 West Broadway, Columbia, MO 65218-0001, except to the extent that action has been taken in reliance on this authorization. A photographic copy of this authorization will be treated in the same manner as the original.

_____
Print Name and Date of Birth of Proposed Insured

_____ _____
Signature of Proposed Insured or Parent if Proposed Insured is a Juvenile Date

_____
Print Name and Date of Birth of Spouse, If Applying

_____ _____
Signature of Spouse, If Applying Date

A copy of this signed form will be provided to the individual upon request.

THIS AUTHORIZATION MEETS THE REQUIREMENTS SET FORTH IN THE HIPAA PRIVACY RULE (45 CFR 164.508).

Detach and leave with Proposed Insured
or owner **ONLY IF** premium is collected with application.

CONDITIONAL COVERAGE RECEIPT

CONDITIONAL COVERAGE RECEIPT - void if altered or modified or if check given in payment is not honored.

NO INSURANCE WILL BE EFFECTIVE BEFORE POLICY DELIVERY TO PROPOSED INSURED OR OTHER OWNER UNLESS ALL THE CONDITIONS ON THIS RECEIPT ARE FULFILLED EXACTLY.

Premium received from _____ Amount $ _____
in connection with the application for insurance made on this date to Shelter Life Insurance Company, 1817 West Broadway, Columbia, Missouri 65218-0001.

Policy Applied For_____ Face Amount $ _____

by _____ _____ _____
Signature of Writing Agent Agent's Number Date

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO SHELTER LIFE INSURANCE COMPANY. DO NOT POSTDATE OR MAKE CHECKS PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

If Shelter Life Insurance Company declines to issue the policy applied for, or issues it other than as applied for, which you do not accept, the payment will be returned.

CONDITIONS PRECEDENT - EFFECTIVE DATE OF INSURANCE

The insurance for which you (Proposed Insured) have applied, will be effective on the date of the application or the date a required medical examination and/or test(s) of any kind is completed, whichever is later, but only if the following conditions are met:

1. You have paid the full premium with the application;
2. You have completed all medical examination requirements;
3. We (Shelter Life Insurance Company), at our Home Office, have determined by our guidelines, that all persons for whom coverage is requested are qualified for the types and amounts of insurance requested at the premium paid.

If the above conditions are not met, no one for whom insurance is requested will be insured unless we offer and you accept the policy under modified terms. That modified policy will be effective on the date approved by us at our Home Office only if (1) we deliver your policy while all persons in the application are alive: (2) to your best knowledge there has been no material change in your answers on the application since the application date; and (3) you have paid any additional premium and/or signed any endorsements required.

CONDITIONAL COVERAGE AMOUNT AND LIMIT - The amount of insurance which may become effective on any person to be insured under the policy applied for prior to delivery will not exceed the lesser of: (a) $250,000, including accidental death benefits, on all pending applications or (b) the amount applied for.

NO AGENT OF SHELTER LIFE INSURANCE COMPANY IS AUTHORIZED TO CHANGE ANY PROVISION OR CONDITION OF THIS RECEIPT.

Detach and leave with Proposed Insured
when application is written.

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. Shelter Life Insurance Company or its reinsurer(s) may, however, make a brief report thereon to **the MIB, Inc., formerly known as Medical Information Bureau**, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is **50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734**.

Shelter Life Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. **Information for consumers about MIB may be obtained on its website at www.mib.com.**

NOTICE OF CONSUMER REPORT

As a part of our normal underwriting procedure, an investigative consumer report may be made to give us applicable information concerning character, general reputation and personal characteristics except as may be related directly or indirectly to the Insured's mode of living of persons to be insured. This information will be obtained through personal interviews primarily with you or your family, friends, neighbors, business associates and financial sources. Upon written request to the Life Underwriting Department at Shelter Life Insurance Company's home office in Columbia, Missouri, additional information as to the nature and scope of the Investigative Consumer Report, if one is made, will be furnished to you.

SHELTER LIFE INSURANCE COMPANY
STATEMENT OF VARIABLITY

FORMS:

Bracketed Field Name on Contract Information page	Description of Variability
INSURED	Insured name
AGE	Ages 0-80, Male or Female
POLICY NUMBER	Lxxxxxxxxx; as assigned by Shelter Life Insurance Company
POLICY DATE	Date
FACE AMOUNT	>=$5,000
MATURITY DATE	Policy Anniversary following the Insured's 120th Birthday
PREMIUM CLASS	Std. Non-Tobacco or Standard
RISK CLASS	Standard or Special
	Paid Up Additional Insurance Rider, Waiver of Premium, Accidental Death Rider, Guaranteed Insurabililty
POLICY RIDERS	Rider, Waiver of Premium Rider for Death or Disability of Payor or blank
ANNUAL, SEMI-ANNUAL, QUARTERLY and	
SPECIAL MONTHLY	Dollar amount of policy premium with modal factors applied
	Paid Up Additional Insurance Rider, Waiver of Premium, Accidental Death Rider, Guaranteed Insurabililty
BENEFIT DESCRIPTION	Rider, Waiver of Premium Rider for Death or Disability of Payor or blank
AMOUNT OF INSURANCE	>=$5,000 for base benefit
	none for Waiver of Premium
	up to 2 times base coverage for Accidental Death Benefit
	up to 2 times base coverage for Guaranteed Insurability Rider
	none for Waiver of Premium Rider for Death or Disability of Payor
ANNUAL PREMIUM	Dollar Amount of Basic Coverage, Dollar Amount of Waiver of Premium
ATTAINED AGE OF INSURED	Ages 1 to 120 - The issue age of the insured plus the end of the policy year.
CASH VALUE	Based on formula in Actuarial Memorandum for specific issue age, rate class and duration.
REDUCED PAID-UP INSURANCE	Based on formula in Actuarial Memorandum for specific issue age, rate class and duration.
EXTENDED TERM INSURANCE YEARS	Based on formula in Actuarial Memorandum for specific issue age, rate class and duration.
EXTENDED TERM INSURANCE DAYS	Based on formula in Actuarial Memorandum for specific issue age, rate class and duration.
LOAN VALUE	Loan Value available in the contract.
VALUATION INTEREST RATE	Compliant with standard valuation requirements.
NONFORFEITURE INTEREST RATE	Compliant with minimum nonforfeiture requirements.
AGENT NUMBER	Varies by writing agent - all in "B354" format
AGENT STATE	Varies by writing agent - all in "24" format